		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041889

Facility Name: CARE CENTRE OF CHAMPAIGN

Address: 1915 S. MATTIS AVE. (Number) CHAMPAIGN (City) 61821 (Zip Code)

County: CHAMPAIGN

Telephone Number: (847)674-4700 **Fax #** (847)674-4733

IDPA ID Number: 36-4082499

Date of Initial License for Current Owners: 6/1/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD., 3750 W. DEVON AVENUE, LINCOLNWOOD, IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,749	1,749	8
9	SNF/PED					9
10	ICF	24,572	4,636		29,208	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,572	4,636	1,749	30,957	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.88%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,749

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	134,299	5,161	5,297	144,757		144,757	(1,392)	143,365			1
2	Food Purchase		133,494		133,494		133,494	(4,445)	129,049			2
3	Housekeeping	80,585	34,090		114,675		114,675	332	115,007			3
4	Laundry	46,816	14,226	622	61,664		61,664		61,664			4
5	Heat and Other Utilities			68,014	68,014		68,014	536	68,550			5
6	Maintenance	28,740	19,198	9,481	57,419		57,419	1,114	58,533			6
7	Other (specify):* SCAVENGER			2,664	2,664		2,664		2,664			7
8	**TOTAL General Services**	290,440	206,169	86,078	582,687		582,687	(3,855)	578,832			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	937,141	105,410	10,736	1,053,287		1,053,287	14,238	1,067,525			10
10a	Therapy		2,321	1,342	3,663		3,663	(14,867)	(11,204)			10a
11	Activities	38,823		2,945	41,768		41,768		41,768			11
12	Social Services	35,054		2,386	37,440		37,440		37,440			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,011,018	107,731	26,409	1,145,158		1,145,158	(629)	1,144,529			16
	C. General Administration											
17	Administrative	27,429		23,000	50,429		50,429	14,214	64,643			17
18	Directors Fees											18
19	Professional Services			61,666	61,666		61,666	7,969	69,635			19
20	Dues, Fees, Subscriptions & Promotions			26,453	26,453		26,453	(8,254)	18,199			20
21	Clerical & General Office Expenses	82,907	12,466	102,537	197,910		197,910	(1,319)	196,591			21
22	Employee Benefits & Payroll Taxes			224,073	224,073		224,073	19,525	243,598			22
23	Inservice Training & Education											23
24	Travel and Seminar			736	736		736	7,144	7,880			24
25	Other Admin. Staff Transportation			1,955	1,955		1,955	8,119	10,074			25
26	Insurance-Prop.Liab.Malpractice			55,739	55,739		55,739	3,713	59,452			26
27	Other (specify):*											27
28	**TOTAL General Administration**	110,336	12,466	496,159	618,961		618,961	51,111	670,072			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,411,794	326,366	608,646	2,346,806		2,346,806	46,627	2,393,433			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN #0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			22,817	22,817		22,817	(5,066)	17,751			30
31	Amortization of Pre-Op. & Org.			439	439		439		439			31
32	Interest			106,262	106,262		106,262	(1,630)	104,632			32
33	Real Estate Taxes			37,997	37,997		37,997		37,997			33
34	Rent-Facility & Grounds			411,805	411,805		411,805	4,573	416,378			34
35	Rent-Equipment & Vehicles			2,001	2,001		2,001		2,001			35
36	Other (specify):*											36
37	**TOTAL Ownership**			581,321	581,321		581,321	(2,123)	579,198			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			60,408	60,408		60,408		60,408			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			125,013	125,013		125,013		125,013			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,411,794	326,366	1,314,980	3,053,140		3,053,140	44,504	3,097,644			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,449)	30		9
10	Interest and Other Investment Income	(1,691)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,445)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,392)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,873)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,006)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(590)	20		28
29	Other-Attach Schedule DEF MAINT	564	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,882)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	70,386	SCHED	34
35	Other- Attach Schedule		ATTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 70,386		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 44,504		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CARE CENTRE OF CHAMPAIGN

ID# 0041889

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEF MAINTENANCE	$ 564	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	564		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,392)	0	0	0	0	0	0	0	0	0	0	(1,392)	1
2	Food Purchase	(4,445)	0	0	0	0	0	0	0	0	0	0	(4,445)	2
3	Housekeeping	0	0	332	0	0	0	0	0	0	0	0	332	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	536	0	0	0	0	0	0	0	0	536	5
6	Maintenance	564	0	550	0	0	0	0	0	0	0	0	1,114	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,273)	0	1,418	0	0	0	0	0	0	0	0	(3,855)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	14,238	0	0	0	0	0	0	0	0	14,238	10
10a	Therapy	0	(55,518)	0	40,651	0	0	0	0	0	0	0	(14,867)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(55,518)	14,238	40,651	0	0	0	0	0	0	0	(629)	16
	C. General Administration													
17	Administrative	0	(23,000)	37,214	0	0	0	0	0	0	0	0	14,214	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	7,798	171	0	0	0	0	0	0	0	7,969	19
20	Fees, Subscriptions & Promotions	(8,596)	0	342	0	0	0	0	0	0	0	0	(8,254)	20
21	Clerical & General Office Expenses	(2,873)	(79,750)	79,889	1,415	0	0	0	0	0	0	0	(1,319)	21
22	Employee Benefits & Payroll Taxes	0	0	15,695	3,830	0	0	0	0	0	0	0	19,525	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,550	594	0	0	0	0	0	0	0	7,144	24
25	Other Admin. Staff Transportation	0	0	6,717	1,402	0	0	0	0	0	0	0	8,119	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,713	0	0	0	0	0	0	0	0	3,713	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(11,469)	(102,750)	157,918	7,412	0	0	0	0	0	0	0	51,111	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,742)	(158,268)	173,574	48,063	0	0	0	0	0	0	0	46,627	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,449)	0	2,383	0	0	0	0	0	0	0	0	(5,066)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,691)	0	61	0	0	0	0	0	0	0	0	(1,630)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,573	0	0	0	0	0	0	0	0	4,573	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,140)	0	7,017	0	0	0	0	0	0	0	0	(2,123)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(25,882)	(158,268)	180,591	48,063	0	0	0	0	0	0	0	44,504	45

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/
				MANAGEMENT		MANAGEMENT
				CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 23,000			$	$ (23,000)	1
2	V	21	BOOKKEEPING FEES	79,750				(79,750)	2
3	V								3
4	V	10a	CHM THERAPY	55,518				(55,518)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 158,268			$	$ * (158,268)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 332	$ 332	15
16	V	5	ELECTRICITY & GAS		" " "		536	536	16
17	V	6	MAINTENANCE		" " "		550	550	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		14,238	14,238	18
19	V	17	ADMIN SALARIES		" " "		37,214	37,214	19
20	V	19	PROFESSIONAL FEES		" " "		7,798	7,798	20
21	V	20	FEES, SUBSCRIPTIONS		" " "		342	342	21
22	V	21	OFFICE EXPENSE		" " "		79,889	79,889	22
23	V	22	EMPLOYEE BENEFITS		" " "		15,695	15,695	23
24	V	24	TRAVEL/SEMINAR		" " "		6,550	6,550	24
25	V	25	TRANSPORTATION		" " "		6,717	6,717	25
26	V	26	INSURANCE		" " "		3,713	3,713	26
27	V	30	DEPRECIATION		" " "		2,383	2,383	27
28	V	32	INTEREST		" " "		61	61	28
29	V	34	OFFICE RENT		" " "		4,573	4,573	29
30	V	35	EQUIPMENT RENT		" " "				30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 180,591	$ * 180,591	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	CHM THERAPY		$ 40,651	$ 40,651	15
16	V	19	PROFESSIONAL FEE		" "		171	171	16
17	V	21	OFFICE EXPENSE		" "		1,415	1,415	17
18	V	22	EMPLOYEE BENEFITS		" "		3,830	3,830	18
19	V	24	TRAVEL & SEMINAR		" "		594	594	19
20	V	25	TRANSPORTATION		" "		1,402	1,402	20
21	V	35	EQUIPMENT RENT		" "				21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 48,063	$ * 48,063	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED				$ 18,275	17-3	1
2	HOWARD GELLER		ADMINISTRATIVE						4,725	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	$ 3,000	$	30,957	$ 332	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839		30,957	536	2
3	6	MAINTENANCE	" " "	279,537	8	4,965		30,957	550	3
4	10	NURSING/MEDICAL RECORDS	" " "	279,537	8	128,566	128,566	30,957	14,238	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	336,038	30,957	37,214	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412		30,957	7,798	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089		30,957	342	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	572,980	30,957	79,889	8
9	22	EMPLOYEE BENEFITS	" " "	279,537	8	141,722		30,957	15,695	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144		30,957	6,550	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651		30,957	6,717	11
12	26	INSURANCE	" " "	279,537	8	33,528		30,957	3,713	12
13	30	DEPRECIATION	" " "	279,537	8	21,518		30,957	2,383	13
14	32	INTEREST	" " "	279,537	8	549		30,957	61	14
15	34	OFFICE RENT	" " "	279,537	8	41,293		30,957	4,573	15
16	35	EQUIPMENT RENT	" " "	279,537	8				0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,630,698	$ 1,037,584		$ 180,591	25

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CHM THERAPY
Street Address: 3856 OAKTON SUTIE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10a	THERAPY	USAGE	100	5	$ 271,007	$ 271,007	15	$ 40,651	1
2	19	PROFESSIONAL FEE	USAGE	100	5	1,143		15	171	2
3	21	OFFICE EXPENSE	USAGE	100	5	9,430		15	1,415	3
4	22	EMPLOYEE BENEFITS	USAGE	100	5	25,530		15	3,830	4
5	24	TRAVEL & SEMINAR	USAGE	100	5	3,963		15	594	5
6	25	TRANSPORTATION	USAGE	100	5	9,348		15	1,402	6
7	35	EQUIPMENT RENT	USAGE	100	5			15		7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,421	$ 271,007		$ 48,063	25

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				214,373			23,150	6
7	SHAREHOLDERS	X		WORKING CAPITAL				879,000			81,875	7
8	RELATED PARTY	X									1,316	8
9	TOTAL Facility Related						$	$ 1,093,373			$ 106,341	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,093,373			$ 106,341	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 36,917	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 37,086	2
3. Under or (over) accrual (line 2 minus line 1).		$ 169	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,828	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 37,997	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997	36,013	9
1998	36,251	10
1999	36,193	11
2000	37,086	12

THE CURRENT YEAR R/E TAX ACCRUAL IS BASED ON ~102% OF THE PRIOR BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX YEAR

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF CHAMPAIGN COUNTY CHAMPAIGN

FACILITY IDPH LICENSE NUMBER 0041889

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	45-20-22-282-005		$ 37,086.00	$ 37,086.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,086.00	$ 37,086.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior CONCRETE Frame STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 5,664
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 439
4. Dates Incurred: 6/96

Nature of Costs: ORGANIZATION COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFING			1996	9,253	237	39	237			9
10	SIDEWALK & PATIO			1996	4,146	277	15	277			10
11	DOOR INSTALLED			1996	636	16	39	16			11
12	HANDRAIL &BUMPER GUARD			1997	2,620	67	39	67			12
13	FLOOR TILES & CARPETS			1997	19,732	506	39	506			13
14	FLOORING, WALLPAPER, CEILING REPAIR			1998	13,669	351	39	351			14
15	ELECTRICAL WORK			1998	7,500	192	39	192			15
16	LANDACAPING			1998	11,551	770	15	770			16
17	DRYWALL/CEILING REPAIR			1999	3,860	99	39	99			17
18	ROOF REPAIR			1999	3,109	80	39	80			18
19	SIDEWALK REPAIR			1999	4,023	268	15	268			19
20	ROOF REPAIR			2000	10,000	364	27.5	364			20
21	WALLPAPER			2000	2,440	598	20	122	(476)		21
22	WALL/CEILING REPAIR			2000	1,425	52	27.5	52			22
23	CURCUIT BREAKERS			2000	710	26	27.5	26			23
24	WALLPAPER/HANDRAILS			2001	7,050	118	27.5	128	10		24
25	FLOOR TILE			2001	1,711	23	27.5	31	8		25
26	FLOOR BASE/WALLPAPER			2001	1,446	11	27.5	26	15		26
27	KICKPLATES			2001	995	5	27.5	18	13		27
28	HVAC UNIT			2001	3,162	5	27.5	57	52		28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 109,038	$ 4,065		$ 3,687	$ (378)	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 111,575	$ 18,720	$ 11,158	$ (7,562)	10 YRS	$ 35,521	71
72	Current Year Purchases	904	32	45	13	10 YRS	45	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	28,609	2,383	2,861	478			74
75	TOTALS	$ 141,088	$ 21,135	$ 14,064	$ (7,071)		$ 35,566	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 250,126	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,751	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,449)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 35,566	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARE CENTER OF CHAMPAIGN

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		118	06/01/96	$ 411,805	25		3
4	Additions							4
5								5
6								6
7	TOTAL		118		$ 411,805 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: AFTER 06/01/16 *

10. Effective dates of current rental agreement:
Beginning 06/01/96
Ending 05/31/21

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 425,871
13.	12/31/2003	$ 436,365
14.	12/31/2004	$ 446,859

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 2,001 Description: SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 35,674	$		$ 35,674	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,421			3,421	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			17,648			17,648	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RESP THERAPIST	39-3				3,665			3,665	13
14	TOTAL			$		$ 60,408	$		$ 60,408	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 118,000)	509,112		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,818		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	274,711		8
9	Other(specify): real estate tax escrow	32,388		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 901,029	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	109,037		15
16	Equipment, at Historical Cost	112,479		16
17	Accumulated Depreciation (book methods)	(80,957)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	345,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 485,559	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,386,588	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 234,586	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,000		28
29	Short-Term Notes Payable	214,373		29
30	Accrued Salaries Payable	53,428		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,087		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,828		32
33	Accrued Interest Payable	146,660		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 693,962	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	879,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 879,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,572,962	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (186,374)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,386,588	$	48

***(See instructions.)**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (419,212)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (419,212)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	232,838	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 232,838	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (186,374)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,211,911	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,211,911	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	67,931	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 67,931	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,691	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,691	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	4,445	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,445	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,285,978	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	582,687	31
32	Health Care	1,145,158	32
33	General Administration	618,961	33
	B. Capital Expense		
34	Ownership	581,321	34
	C. Ancillary Expense		
35	Special Cost Centers	60,408	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,053,140	40
41	**Income before Income Taxes (line 30 minus line 40)****	232,838	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 232,838	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,420	3,660	$ 91,382	$ 24.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,421	4,596	99,598	21.67	3
4	Licensed Practical Nurses	8,446	8,708	162,063	18.61	4
5	Nurse Aides & Orderlies	45,871	45,996	531,331	11.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	984	984	14,059	14.29	8
9	Activity Director	2,075	2,099	19,820	9.44	9
10	Activity Assistants	2,583	2,684	19,003	7.08	10
11	Social Service Workers	3,919	4,007	35,054	8.75	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	30,993	14.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,107	7,265	64,779	8.92	15
16	Dishwashers	5,743	5,937	38,527	6.49	16
17	Maintenance Workers	1,940	2,052	28,740	14.01	17
18	Housekeepers	9,318	9,854	80,585	8.18	18
19	Laundry	6,438	6,526	46,816	7.17	19
20	Administrator	1,014	1,070	27,429	25.63	20
21	Assistant Administrator					21
22	Other Administrative	2,838	3,014	29,403	9.76	22
23	Office Manager	1,983	2,071	31,788	15.35	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,958	2,054	21,716	10.57	31
32	Other Health C: care plan coord	1,960	2,080	38,708	18.61	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,978	116,737	$ 1,411,794 *	$ 12.09	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,158	1-3	35
36	Medical Director		9,000	9-3	36
37	Medical Records Consultant		2,135	10-3	37
38	Nurse Consultant		6,188	10-3	38
39	Pharmacist Consultant		825	10-3	39
40	Physical Therapy Consultant		454	10a-3	40
41	Occupational Therapy Consultant		325	10a-3	41
42	Respiratory Therapy Consultant		325	10a-3	42
43	Speech Therapy Consultant		238	10a-3	43
44	Activity Consultant		98	11-3	44
45	Social Service Consultant		2,386	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,132		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	71	1,481	10-3	52
53	TOTAL (lines 50 - 52)	71	$ 1,481		53

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rene Thompson	ADMINISTRATOR	0	$ 5,292
Dennis Wasson	ADMINISTRATOR	0	15,969
Judy Weger	ADMINISTRATOR	0	6,168
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 27,429

B. Administrative - Other

Description	Amount
MANGEMENT FEES	$ 23,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 23,000

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK,BOKOR,KAGDA	ACCTG SVCS	$ 11,600
CERTIFIED HEALTH	ADMIN CONSULT	30,625
ECONOCARE	PURCH CONSULT	2,124
PERSONNELL PLANNERS	HR CONSULT	1,688
MILLENIUM/PAYMASTER	DATA PROCESSING	4,615
WINSTON & STRAWN	LEGAL	5,276
STONE,MCGUIRE,BENJAMAIN	LEGAL	4,260
CHAMPAING CARE	LEGAL	1,196
KOVITZ,SHIFRIN	LEGAL	25
MICHAEL BEST & FREDRICH	LEGAL	47
SACHOFF&WEAVER	LEGAL	210
RELATED PARTY		7,969
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 69,635

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,886
Unemployment Compensation Insurance	23,297
FICA Taxes	108,002
Employee Health Insurance	55,747
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other EE Benefits	141
RELATED PARTY	19,525
TOTAL (agree to Schedule V, line 22, col.8)	$ 243,598

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,157
Health Care Worker Background Check (Indicate # of checks performed)	
ADVERTISING	8,006
DUES,BOOKS, SUBSC	7,432
LICENSE, PERMITS	2,268
YELLOW PAGE ADV	590
RELATED PARTY	342
Less: Public Relations Expense	( )
Non-allowable advertising	(8,006)
Yellow page advertising	(590)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,199

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
	736
RELATED PARTY	7,144
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,880

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 3,387	3	$ 565	$ 1,129	$ 1,129	$ 564	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,387		$ 565	$ 1,129	$ 1,129	$ 564	$	$	$	$	$

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC $7,799

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NO

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 4 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 64,605
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: CARE CENTRE OF CHAMPAIGN #0041889 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,158	
	REPAIRS & MAINTENANCE		139	
				5,297
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		622	
			0	622
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		16,882	
	ELECTRICITY		35,267	
	WATER		15,424	
	CABLE TV - LOBBY		441	
			0	68,014
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,154	
	PAINTING & DECORATING		25	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,153	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,397	
	FIRE SERVICE		752	
			0	
			0	9,481
7	**OTHER**			
	SCAVENGER		2,664	
	SECURITY SERVICE		0	2,664
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,481	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		107	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,135	
	PHARMACY CONSULTANT	XVIII B 39-2	825	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	6,188	
			0	
			0	10,736
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	454	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	325	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	325	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	238	1,342
11	**ACTIVITIES**			
	ACTIVITY PROGRAM EXP		2,847	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	98	
			0	2,945
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,386	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,386
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRAIRIE VIEW CARE CENTER OF CHARLESTON ##40311 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	23,000	23,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,615	
	ADMINISTRATIVE CONSULTANTS	XIX C	30,625	
	PROFESSIONAL FEES	XIX C	26,426	
			0	61,666
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,006	
	EMPLOYEE WANT ADS	XIX F	8,157	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,432	
	LICENSES & PERMITS	XIX F	2,268	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	590	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	26,453
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		5,100	
	EQUIPMENT REPAIR & MAINTENANCE		2,706	
	OUTSIDE CLERICAL SERVICES		79,750	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,873	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		352	
	TELEPHONE		7,943	
	STORAGE		1,190	
	POSTAGE		2,623	102,537

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	108,002	
	UNEMPLOYMENT COMPENSATION	XIX D	23,297	
	WORKERS COMPENSATION INSURANC	XIX D	36,886	
	HOSPITALIZATION INSURANCE	XIX D	55,747	
	EMPLOYEE BENEFITS - OTHER	XIX D	141	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	OTHER	XIX D	0	224,073
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	736	
	TRAVEL	XIX G	0	
			0	
			0	736
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,955	1,955
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		55,739	55,739
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 608,646